Sun Life GREPA Financial

# Application by the Policy Owner

## Advanced Benefit/Terminal Illness/Living Benefit Rider

Please PRINT clearly.
Use BLACK ink.

In this form, *"you"* and *"your"* refer to the policyowner and life insured whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco Group of Companies.

You hereby request the Company for an advance of the portion of the death benefit on the policy/ies indicated herein under the provisions of the rider ticked below.

This claim is for (Please check appropriate box):

☐ Advanced Benefit for Critical Care Rider ☐ Terminall Illness Benefit ☐ Living Benefit Rider

## 1 General Information

The policy/ies must be attached to this application.

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|---|
| Policy Owner (Last Name, First Name, M.I.) |
| Policy Number(s) |
| Life Insured if other than Policy Owner (Last Name, First Name, M.I.) |

## 2 Signatures

This section must be signed by the policy owner, life insured and the appropriate persons as indicated.

Please indicate date of signing after each signature.

By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs. If you need more information about our privacy policy, please visit https://www.sunlifegrepa.com/LegalPrivacySecurity.aspx.

| | |
|---|---|
| Signature of Policy Owner<br>X | Signature of Life Insured if other than Policy Owner<br>X |
| Date and Place of Signing | Date and Place of Signing |
| Signature of Irrevocable Beneficiary, if any<br>X | Printed Name |
| Signature of Irrevocable Beneficiary, if any<br>X | Printed Name |
| Signature of Witness<br>X | Printed Name |
| Address | Telephone No. |
| Place of Signing | Date of Signing (day/month/year) |

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## Authorization to disclose information

This statement must be signed by the life insured. If that person is under 18 years of age, a parent must sign.

By signing below, the life insured hereby authorizes and directs release to the Company or its duly authorized representative of any information, including personal health information, about the life insured, by any physician, health care provider, hospital or other medical facility. A copy of this authorization shall be valid as the original.

| | |
|---|---|
| Signature of Life Insured if age 18 and over<br>X | Printed Name of Life Insured |
| Signature of Parent if life insured is under age 18<br>X | Printed Name of Parent |

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